

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 05/09/2023
NAME OF PROVIDER OR SUPPLIER: BRADFORD REGIONAL MEDICAL CENTER STATE LICENSE NUMBER: 541201		STREET ADDRESS, CITY, STATE, ZIP CODE: 116 INTERSTATE PARKWAY PO BOX 218 BRADFORD, PA 16701			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE	
P 0000	<p>INITIAL COMMENT</p> <p>This report is the result of an unannounced onsite complaint investigation (CHL23C251A) completed on May 9, 2023, at Bradford Regional Medical Center. These allegations were investigated in a previous special monitoring survey, and the facility is required to submit an acceptable Plan of Correction.</p> <p>See the survey PJ0G11 with an exit date of May 2, 2023:</p> <p>§101.31(5) Hospital Requirements §107.13(2) Content of Bylaws, Rules, and Regulations</p>	P 0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:



Certified End Page

BRADFORD REGIONAL MEDICAL CENTER

STATE LICENSE NUMBER: 541201

SURVEY EXIT DATE: 05/09/2023

**I Certify This Document to be a True and Correct Statement of Deficiencies and
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in black ink that reads "Jeane Parisi".

Jeane Parisi
Deputy Secretary for Quality Assurance

A handwritten signature in black ink that reads "Debra L. Bogen MD".

Debra L. Bogen, MD, FAAP
Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY